

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-001636

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 368

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED FEB 6 1963

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clay</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Length of stay in 1b <u>20 yrs.</u>	c. CITY OR TOWN <u>Kansas City, Mo.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ASB BRIDGE</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside give location) <u>3706 E. 35th Street</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>P.</u> Last <u>HESHION</u>	4. DATE OF DEATH Month <u>January</u> Day <u>19</u> Year <u>1963</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8-22-1901</u>	9. AGE (last birthday) <u>61</u>	IF UNDER 1 YEAR Months <u>61</u> Days <u></u> Hours <u></u> Min. <u></u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>ADVERTISING</u>	11. BIRTHPLACE (City and state or country) <u>Linn, Kansas</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>John Heshion</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Travers</u>	14. NAME OF HUSBAND OR WIFE <u>Julia Heshion</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>[redacted]</u>	17. INFORMANT <u>Julia Heshion</u> Address <u>3706 E. 35th St.</u>
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18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO (b) <u>arteriosclerotic Heart Disease</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u></u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u></u>	PART III. If deceased was female, was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>Was in a 3 Car Collision</u>
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20c. TIME OF INJURY Hour <u>1-19-63</u> Month, Day, Year <u>1-19-63</u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>ASB Bridge</u>	20f. CITY, TOWN, OR LOCATION <u>Kansas City</u>	COUNTY <u>Jackson</u> STATE <u>Mo.</u>
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21. I attended the deceased from _____ to _____ and last saw him alive on _____	Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated:
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22a. SIGNATURE (Degree or title) <u>Ralph H. Owens, Coroner</u>	22b. ADDRESS <u>152 Union Station</u>	22c. DATE SIGNED <u>1-21-63</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	23b. DATE <u>Jan 22, 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>	23d. LOCATION (City, town, or county) <u>Kansas City, Missouri</u>
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24. FUNERAL DIRECTOR <u>D. H. Newcomer</u>	25. DATE RECD. BY LOCAL REG. <u>1-21-63</u>	26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF H. H. OWENS MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Harold D. Reich

Licensed Embalmer No.

4998

P. O. Address

K. E. Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.